(please detach – keep the above for your records) **office use only**_____

Maryland Criminal Injuries Compensation Board
Suite 206, Plaza Office Center ◆ 6776 Reisterstown Road ◆ Baltimore, MD 21215-2340
410-585–3010 or 1-888-679-9347 fax 410-764-3815 www.dpscs.state.md.us/cicb

Application for Crime Victim Compensation

(Please print clearly and fill out both sides in blue/black ink)

Victim: _____ **Social Security No.**_____
(First) (Middle) (Last)
Address: _____
City and State: _____ **Zip Code:** _____ **Phone:** _____
Date of birth: _____ **Sex: M**_____ **F** _____

Claimant: _____ **Social Security No.**_____
(If victim is a minor or deceased)
Address: _____
City and State:_____ **Zip Code:** _____ **Phone:** _____
Date of birth: _____ **Sex: M** ____ **F** ____ **Relationship to Victim:**_____

Date of Crime: _____ **Time:** _____ a.m./p.m.
Location: _____
Name of Offender (if known):_____ **Relationship to Offender** (If any)_____
Brief description of crime: _____
_____
Date crime was reported to police: _____ **Time:** _____ a.m./p.m.
If crime not reported within 2 days, explain why: _____
Which Police Department: _____**Police Complaint Number:** _____
Has the offender been arrested? Yes/No **Has a warrant for arrest been issued?** Yes/No
Has prosecution begun? Yes/No **Name of Court:** _____**Case Number:** _____
Disposition:_____
Restitution if any and how much paid to date:_____

If applying for lost wages:

_____ _____
Employer's Business Name **Contact person/Phone Number**

_____ _____
Street Address **City/State/Zip Code**

Lost time: From_____ To_____
Do/Did you receive any type of support (sick/annual leave, vacation, disability, workman's comp, etc.)?
_____
PLEASE ATTACH COPIES OF MOST RECENT PAYSTUBS AND W2s

Description of Injuries:_____
List names of hospitals, doctors, dentists, etc. who gave treatment. (Send copies of all bills if available)

Name	**Address**	**City/State/Zip**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In cases of homicide, enclose a copy of the death certificate and itemized funeral bills and provide the following:

_____ _____
Funeral Home **Telephone Number**

_____
Address **City** **State** **Zip Code**

Total funeral expenses: _____ **Amount paid by claimant:** _____
Amount paid by others: _____ **Amount still due funeral home:** _____

Did you receive any other financial benefits as a result of the death of the victim? Yes/No
If "yes", please describe: _____

Indicate whether the claimant/victim was covered by any of the following:

Medical Insurance	Yes/No	Carrier: _____ Policy No._____
Medical Asst/Medicare	Yes/No	Account No.:_____
Social Services Benefits	Yes/No	_____
Life Insurance	Yes/No	Carrier: _____ Amount _____
Social Security	Yes/No	Amount payable to survivors (if any) _____
Other	Yes/No	_____

For loss of support for a child, attach a copy of the birth certificate and if applicable, Social Security Survivor Benefits statement. For a spouse, attach a copy of the marriage certificate.

Dependents Name	**Date of Birth**	**Relationship**	**Guardian (if minor)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If applying for lost wages: Income available to claimant/victim (including spouse)

Wages/Salaries $_____
Self-employment income $_____
Child Support $_____
Other _____

Optional:
The following victim information is used for statistical purposes only. It is to be used only to comply with federal regulations.
Race: ❑ White ❑ Black ❑ Hispanic ❑ American Indian ❑ Asian/Pacific Islander ❑ Other
Name of country where born _____

Who referred you? ❑ Police ❑ Prosecutor ❑ Victim Svcs. ❑ Hospital ❑ Attorney ❑ Poster/Brochure ❑ Other

Attorney Representation: (Complete only if represented by an attorney for this claim)

_____ _____
Attorney's name (Last, First and Middle) Phone Number and Fax Number

_____ _____
Address City State Zip Code

The claimant affirms that **no release or compromise** has been or will be given by the claimant to any third party who may be liable in damages to the claimant based on the incident described in this claim. If the claimant receives an award from the Criminal Injuries Compensation Board as a result of this application and later recovers damages or other payments from a third party, the claimant agrees to **repay** to the said Board the amount of such award to the extent of such recovery.

The claimant authorizes any health care provider, employers of the claimant or victim, law enforcement authorities, courts, insurance companies, financial institutions, State or Federal Government agencies, or other persons or organizations having pertinent information to **release** to the Criminal Injuries Compensation Board such information as may be relevant in evaluating this claim. The authorization duration shall be until the completion of all steps in processing and determining a claim, including any appeals to any other agency or court. The claimant also agrees that statistics and information relevant to the claim may be released as needed for reporting, for processing, for response to federal and/or state legislative, executive and/or judicial units consistent with the limitations of law. Claimant specifically waives any requirement that he or she be given notice of any request being made to any information provider.

The claimant consents to the payment of any award for outstanding indebtedness of the claimant arising from this claim to be paid **directly** to health care providers, funeral homes, or attorneys, as appropriate.

I hereby **declare and affirm**, under the penalties of perjury, that the information and statements given in this claim form are true and correct to the best of my knowledge, information and belief.

Signature of claimant_____**Date**_____